CENTERS FOR MEDICARE & MEDIC SERVICES 45th 7/13011' FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445469	A. BUILDING _____ B. WING _____	06/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY HALL NURSING HOME	301 WATAUGA AVE ELIZABETHTON, TN 37643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During annual recertification survey and complaint survey #26331 conducted June 13-June 15, 2011, at Ivy Hall Nursing Home, no deficiencies were cited in relation the the complaint under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000	Disclaimer for Plan of Correction Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Ivy Hall Nursing Home of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Ivy Hall Nursing Home files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to implement the care plan for one (#7) of twenty-two residents reviewed. The findings included: Resident #7 was admitted to the facility on November 7, 2008, with diagnoses including Altered Mental Status, Dementia, and Cerebrovascular Accident. Medical record review of the Plan of Care reviewed on May 18, 2011, revealed the resident had a history of skin tears and geri-sleeves were to be applied to the arms. Observation on June 15, 2011, at 8:20 a.m., revealed the resident sitting in a wheelchair, near the nursing station. Continued observation	F 282	**F 282** Ivy Hall Nursing Home believes its current practices were incompliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: Corrective Actions for Targeted Residents Geri-sleeves were immediately placed on Resident #7 by a licensed nurse on 6/15/11.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Judy C. Hall Leach TITLE Administrator (X6) DATE 6-28-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	INITIAL COMMENTS During annual recertification survey and complaint survey #26331 conducted June 13-June 15, 2011, at Ivy Hall Nursing Home, no deficiencies were cited in relation the the complaint under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000	(F 282 Continued) Identification of Other Residents with Potential to be Affected Residents care planned for utilizing geri-sleeves have the potential to be affected by this practice. Current residents care planned for geri-sleeves were checked on 6/24/11 by the Director of Nursing to ensure proper placement. Systematic Changes Nursing staff was in-serviced on 6/24/11 by the Director of Nursing and the Assistant Director of Nursing regarding the importance of interventions being in place as care planned. Newly hired employees will be educated to the same during orientation period by the Assistant Director of Nursing. Monitoring An audit will be conducted by the Assessment Nurse to ensure that interventions for residents are in place per care plan. This audit will be conducted monthly for three months, then quarterly. The Assessment Nurse will report audit findings to the Performance Improvement Committee for review and to ensure ongoing compliance. This committee consists of the Administrator, Assistant Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, MDS Nurse, Assessment Nurse, Social Service Director, Marketing Director, Activities Director, Food Services Manager, Medical Records Clerk, Maintenance Director, and Therapy Director.	6/24/11
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to implement the care plan for one (#7) of twenty-two residents reviewed. The findings included: Resident #7 was admitted to the facility on November 7, 2008, with diagnoses including Altered Mental Status, Dementia, and Cerebrovascular Accident. Medical record review of the Plan of Care reviewed on May 18, 2011, revealed the resident had a history of skin tears and geri-sleeves were to be applied to the arms. Observation on June 15, 2011, at 8:20 a.m., revealed the resident sitting in a wheelchair, near the nursing station. Continued observation	F 282		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judy C. McCoach | TITLE: Administrator | (X6) DATE: 6-28-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	Continued From page 1 revealed the resident was dressed with a short sleeve top, without the geri-sleeves applied. Observation and interview, on June 15, 2011, at 8:40 a.m., with the Director of Nursing, at the nursing station, revealed the resident sitting in the wheelchair, near the nursing station, and confirmed the geri-sleeves were not applied to the resident's arms.	F 282		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, the facility failed to appropriately administer medications in three of fifty-one opportunities, resulting in a 5.88% medication error rate. The findings included: Observation on June 14, 2011, at 8:16 a.m., revealed Licensed Practical Nurse (LPN) #2 administering medications to resident #21. Continued observation revealed resident #21 was completing the breakfast meal. Continued observation revealed LPN #2 administered metoclopramide (medication for gastroesophageal reflux disease) 5 mg (milligrams), and omeprazole (medication for gastroesophageal reflux disease) 20 mg to the resident.	F 332	**F 332** Ivy Hall Nursing Home believes its current practices were incompliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: Corrective Actions for Targeted Residents The schedule for medications to be given before meals was changed for Resident #21 to ensure that ac medications are taken prior to meals. Discontinued medication was removed from 7-day unit dose roll of medications for Resident #22. Identification of Other Residents with Potential to be Affected Due to the nature of this practice, current residents have the potential to be affected. Medication carts throughout the facility were checked for discontinued medications and these drugs were removed by the Floor Nurse on 6/15/11. Discontinued medications were highlighted in yellow on the MARs by the Floor Nurse on 6/15/11.	

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F 282	Continued From page 1 revealed the resident was dressed with a short sleeve top, without the geri-sleeves applied. Observation and interview, on June 15, 2011, at 8:40 a.m., with the Director of Nursing, at the nursing station, revealed the resident sitting in the wheelchair, near the nursing station, and confirmed the geri-sleeves were not applied to the resident's arms.	F 282	**(F 332 Continued)** Systematic Changes An in-service was conducted on 6/24/11 by the Director of Nursing and Assistant Director of Nursing to educate current nursing staff on the 5 Rights of medication administration. Newly hired employees will be educated by the Assistant Director of Nursing regarding the same topic during their orientation period.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, the facility failed to appropriately administer medications in three of fifty-one opportunities, resulting in a 5.88% medication error rate. The findings included: Observation on June 14, 2011, at 8:16 a.m., revealed Licensed Practical Nurse (LPN) #2 administering medications to resident #21. Continued observation revealed resident #21 was completing the breakfast meal. Continued observation revealed LPN #2 administered metoclopramide (medication for gastroesophageal reflux disease) 5 mg (milligrams), and omeprazole (medication for gastroesophageal reflux disease) 20 mg to the resident.	F 332	Monitoring An audit will be conducted by the Assessment Nurse regarding proper medication administration with return demonstration by current nurses. This audit will be conducted monthly for three months, then quarterly. Newly hired nurses will be observed during medication administration while in their orientation period. The Assessment Nurse will report the audit findings to the Performance Improvement Committee for review and to assure compliance. This committee consists of the Administrator, Assistant Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, MDS Nurse, Assessment Nurse, Social Service Director, Marketing Director, Activities Director, Food Services Manager, Medical Records Clerk, Maintenance Director, and Therapy Director.	6/24/11

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F 332	Continued From page 2 Medical record review of the June 2011, physician's recapitulation orders revealed "...omeprazole cap (capsule) 20 mg one capsule PO (by mouth) before breakfast...Metoclopram tab (tablet) 5 mg one tablet PO before meals and at bedtime..." Interview on June 14, 2011, at 8:20 a.m., with LPN #2, in the hallway, confirmed the metoclopramide and the omeprazole were not administered before breakfast as ordered by the physician. Observation on June 15, 2011, at 8:10 a.m., revealed LPN #1 administering medications to resident #22. Continued observation revealed LPN #1 administered Detrol LA (medication for overactive bladder) 4 mg to resident #22. Medical record review of a physician's order dated June 4, 2011, revealed the Detrol LA was discontinued. Interview on June 15, 2011, at 8:20 a.m., with LPN #1, in the hallway, confirmed the Detrol LA was administered in error.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility policy, observation, and interview, the	F 333	**F 333** Ivy Hall Nursing Home believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	

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F 333	Continued From page 3 facility failed to prevent a significant medication error for one (#9) of twenty-two residents reviewed. The findings included: Resident #9 was admitted to the facility on February 16, 2009, with diagnoses including Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, and History of Alcohol Abuse. Medical record review of the nursing note dated (December 17, 2010) revealed, "...VS (vital signs) P (pulse) 76 R (respirations) 14 B/P (blood pressure) 98/62...This nurse was called by CNA (certified nursing assistant) to smoking room to observe pt (patient) who was exhibiting a change in physical coordination and lethargy...notified (named physician)-sent to ER (emergency room)..." Medical record review of the Emergency Department Initial History Assessment dated December 17, 2010, revealed, "...Chief Complaint/Initial Assessment: Given wrong meds...re-evaluation...improved...may return to NH (nursing home) for observation..." Medical record review of the nursing note dated December 17, (2010), revealed, "...meds given...Ativan 0.5 mg (milligrams) (anti-anxiety), Clonazepam 0.5mg (anti-seizure), Percocet 5mg (pain), Nortriptyline 50mg (Antidepressant), Ranitidine 150mg (anti-ulcer), Baclofen 15mg (skeletal muscle relaxer)..." Medical record review of the nursing note dated	F 333	Corrective Actions for Targeted Residents Resident #9 was sent to the ER on 12/17/10 immediately after the medication error was made. Resident returned to the facility within two hours. The nurse who made the medication error was counseled on the 5 Rights of medication administration by the Assistant Director of Nursing on 12/18/11. Identification of Other Residents with Potential to be Affected Due to the nature of this practice, current residents have the potential to be affected. Systematic Changes Licensed Nurses were educated by the Director of Nursing and Assistant Director of Nursing on 6/24/11 regarding the 5 Rights of medication administration. Newly hired employees will be educated to the same during their orientation period. Monitoring An audit will be conducted by the Assessment Nurse for Licensed Nurses regarding the 5 Rights of medication administration, with return demonstration. This audit will be completed monthly for three months, then quarterly. Newly hired Licensed Nurses will be observed during medication administration during their orientation period. The Assessment Nurse will report audit findings to the Performance Improvement Committee for review and determination of continued compliance. This committee consists of the Administrator, Assistant Administrator, Medical Director, Director of	

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F 333	Continued From page 4 December 18, 2010, revealed, "...1:30 A (a.m.)...R 20 P 79 B/P 117/68. Resident returned via (ambulance), no acute distress noted..." Review of the facility policy, Medication Administration-Unit Dose Cart System, revealed, "...to correctly administer medications as prescribed ...push cart to resident area. Call resident by name and inform him/her of medication and check identification...Read label three times before administering medication..." Observation on June 13, 2011, at 12:45 p.m., revealed the resident lying on the bed with eyes closed. Interview on June 14, 2011, at 2:45 p.m., in the conference room, with LPN (Licensed Practical Nurse) #3, confirmed the Ativan, Clonazepam, Percocet, Nortriptyline, Ranitidine and Baclofen were administered to the resident in error. Interview on June 16, 2011, at 12:45 p.m., with the Assistant Director of Nursing, in the conference room, confirmed a significant medication error had occurred when the medications had been administered.	F 333	Nursing, Assistant Director of Nursing, MDS Nurse, Assessment Nurse, Social Service Director, Marketing Director, Activities Director, Food Services Manager, Medical Records, Maintenance Director, and Therapy Director.	6/24/11